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	295077	A. BUILDING _____ B. WING _____	05/22/2009

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on May 18 through May 22, 2009 in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 158 residents. The sample size was 24 sampled residents which included 3 closed records, and 3 unsampled residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to notify the physician of the potential need for his intervention for 3 of 29 residents (#2, #9, #30).

Findings include:

Resident #2

Resident #2 was admitted to the facility on 10/15/08, with diagnoses of Alzheimer's Disease, diabetes type II, and hypertension. She had a colostomy from a previous intestinal surgery.

Review of the records disclosed a physician's order for a mammogram due to a "lump". Results of the mammogram could not be located in the chart. Employee #6, the Unit Manager, when interviewed on 5/18/09, was not aware of the results of the test. After calling the Mammogram Center, it was determined that the test had not been performed until 5/07/09, due to the resident

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having an episode of vomiting. There was no evidence in the record that the physician had been notified of the delay in completing the test or that he had been notified of the results of the mammogram. Employee #6 notified the physician of the test results on 5/19/09.

Resident #30

During observation of the medication pass (on 300 Hall) during the morning of 5/19/09, it was noted that an unsampled resident, #30, was given two Tylenol. The medication nurse, Employee #21, added some powder to a glass of water before giving the water to the resident to take with the Tylenol. The nurse explained that the resident had some difficulty swallowing so that she gave thickened water with her medication.

When asked how she mixed the powder into the water, Employee #21, responded that she put in a couple of "squirts" which she stirred for a brief time. If it was not thickened enough, she added some more. The facility policy for Thickened Liquids disclosed that there were three consistency levels. Once a consistency level had been identified in the physician's order, the policy contained a formula as to how much thickener (measured in teaspoons and tablespoons) was to be added to to a specific number of cc (cubic centimeters) The number of cc was based on the type of liquid to be thickened. The liquid was then to be stirred for 15 seconds.

Review of the medical record for Resident #30 did not reveal any evidence that the physician had ordered thickened liquids for Resident #30.

Resident #9

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F 157	Continued From page 3 Resident #9 was a 93 year old resident who has resided at the facility since November, 2006, with diagnoses of vascular dementia, hypothyroidism and hypertension. Her minimal data sets for the past 15 months revealed that her cognition level has not changed, it remained a two, which indicated "moderately impaired, decisions poor, cues/supervision required". Review of Resident #9's record revealed that she refused to allow staff to obtain a lab specimen that was ordered for 5/4/09, to follow up abnormal thyroid test results from eight weeks before. This lab test was not obtained until 5/15/09. There was no documentation that the physician was notified that Resident #9 had refused this lab test daily for ten days. An interview with the registered nurse (RN) in charge (Employee #6) on 5/18/09, revealed that the physician should have been informed of Resident #9's lab work. The facility policy was requested to Employee #6, but was not provided by the end of the survey. Employee #6 confirmed there was no evidence to demonstrate the physician or family were notified. Employee #6 did not know where the lab results of the test obtained three days earlier and had to call the lab for a copy of the results, so that the physician could be notified.	F 157		
F 170 SS=C	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.	F 170		

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F 170	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on resident and facility interview, the facility failed to ensure that residents had received mail on all regularly scheduled mail delivery days, specifically Saturdays. Findings include: During a group resident meeting on Tuesday, 5/19/09, it was identified that the residents attending were not aware of whether there was mail delivery to the residents on Saturdays. An interview with the Administrator at 8:55 AM on 5/20/09, revealed that the facility did not provide for any mail delivery from the community post office on Saturdays, because there was no one in the business office to accept the mail. The Administrator also stated that there was no receptionist at the front desk to receive the mail on Saturday. This included any mail that was directed to the residents. The Administrator confirmed there were activity and nursing staff working on Saturday who could receive and even distribute the mail directed to residents on Saturdays. Telephone interviews on 5/21/09 and 5/22/09, with the postmaster for the post office providing mail service to the facility confirmed mail delivery was available on Saturdays to the facility. She acknowledged that although there wasn't anything in writing, she had interviewed the carrier who confirmed that it was an arrangement with the facility that no mail would be delivered on Saturdays. Note: The postmaster confirmed mail would start	F 170		

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F 170	Continued From page 5 being delivered on Saturdays, specifically this Saturday 5/23/09.	F 170		
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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This REQUIREMENT is not met as evidenced by:
Based on interview and policy and procedure review, the facility failed to ensure that allegations of abuse or injuries of unknown origin were reported to the administrator and investigated as required for two of 26 residents (#25, #26), and failed to ensure background checks were completed on all employees for two of 12 (#6, #8) personnel.

Findings include:

Resident #25

On 5/20/09, at 11:20 AM, Resident #27 was interviewed. She reported concerns of a certified nursing assistant (CNA) "tormenting" her roommate. She reported the CNA, Employee #8 had entered the room quietly, then would yell, "Rarrh!" loudly, startling her roommate, Resident #25. Another time, the same CNA had grabbed the roommate by the ribs and was shaking her, startling her. She stated a third incident that startled her roommate occurred when Employee #8 "snapped" two adult briefs against the closet making a loud noise. Resident #27 stated she reported these incidents to the Director of Social Services, approximately three to four weeks ago. She stated Employee #8 was no longer behaving in that manner. The last incident occurred prior to her reporting the incident.

On 5/20/09, the Director of Nurses (DON), Employee #2, was interviewed. She stated that all allegations of abuse are investigated and discussed in the daily Interdisciplinary Team (IDT)

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meeting. She stated she was not aware of any allegations of abuse involving Employee #8.

The Director of Social Services, Employee # 3, was interviewed. Employee #3 confirmed she had taken a report from Resident #27, and had reported it to "someone". She had no explanation as to why she did not report it to either the DON or Administrator or bring it up during the daily IDT meeting. Review of the Director of Social Services note for the account revealed she noted Employee #8 "walked into room went to resident's (#25) bedside and 'goosed' her in the ribs and made her jump..." An additional note, dated 4/8/09, documented, "... Came in to get briefs-got some, as he (Employee #8) went by bathroom door he smacked the briefs on the door making both residents in the room jump."

Resident #25's record was reviewed and revealed she had diagnoses of Alzheimer's disease and dementia. Resident #25 was interviewed. She stated a male CNA had shaken her and it scared her when it happened.

On 5/21/09, at 10:20 AM, Employee #8 was interviewed. He stated he was just joking around with Resident #25. He stated he has cared for her for a couple of years and she liked the joking around. He stated he would never kick the footboard of the bed as that would injure his foot. He denied shaking Resident #25, stating she is hard of hearing, and sometimes he would try to rouse her by shaking her shoulder. He denied making any loud noises or snapping the briefs to make a loud noise. He stated the charge nurse, Employee # 5, talked with him about not kidding around with the residents.

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On 5/21/09, at 11:00 AM, the charge nurse, Employee #5, was interviewed. She stated she knew nothing of the allegation of abuse with Employee #8. She stated she noticed that he was joking around with Resident #25, and talked with him, telling him his behavior might be misinterpreted. Employee #5 stated the Director of Social Services did not talk with her regarding the allegations.

On 5/21/09, at 11:05 AM, the unit manager, Employee #6, was interviewed. She stated she did not recall the Director of Social Services talking to her regarding the allegations of abuse by Employee #8.

Resident #26

Resident #26 record was reviewed and revealed on 4/15/09 at 9:00 PM, the following entry in the nursing notes, "...Noted to have old yellowish bruise on the L (left) forehead, daughter ... aware."

On 5/6/09, the Director of Nurses (DON) was interviewed. The facility incident reports were reviewed. There were two incidents regarding Resident #26. A bruise was noted on her right arm on 4/10/09, and the resident had a fall on 3/29/09. The DON was unaware of any large bruise on the resident's forehead. There was no incident report or investigation regarding the bruise noted on 4/15/09.

On 5/6/09, at 2:15 PM, the evening nurse, Employee #7, was interviewed. She acknowledged she wrote the entry in the resident's record regarding the old bruise noted.

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She stated that it actually was not a bruise, but was a "food stain, like curry", and came off with a washcloth. She stated the resident was sitting in a wheelchair across from the nurses station when she noted it. She had no explanation of why she did not amend the nurses note to reflect her change in assessment of the bruise. She stated she did not report the bruise to the DON.

A photograph, taken on 4/15/09 at 6:51 PM, provided by Resident #26's daughter revealed the resident with a large bruise, approximately 3 inches long, and varying in width. The bruise was purplish blue at the eyebrow and extended to the receding hairline, and was yellowish green at the hairline. A small reddened line, lateral across the bruise, possibly a laceration, was noted in the center of the bruise.

The facility's policy, "Investigation & Reporting of Alleged Abuse," was reviewed and revealed, "It is the policy ... to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator of the facility...The facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Administrator or his or her designee..."

Employee Background

On 5/20/09, employee personnel files were reviewed. Personnel Record Employee (PRE) #6 was hired 3/1/08 as a CNA. PRE #8 was hired 2/26/08 as a CNA. The fingerprints for both PRE #6 and #8 were rejected. The facility failed to

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F 225	Continued From page 10 re-submit them. Consequently, there were no background checks completed on PRE #6 and #8.	F 225		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, and interview, the facility failed to ensure that residents received care which maintained or enhanced the individual's dignity and respect in 2 of 24 residents (#21, #16) and 4 unsampled residents (#28, #29, #31, #32). Findings include: Residents #21 and #32. A discussion of residents attending the group meeting revealed that two male residents acknowledged that if they were in the bathroom, on the toilet, staff would enter the bathroom and perform non emergency care. The two specific instances included a CNA entered to empty the Foley catheter drainage bag (Resident #21, #32) and a nurse who wanted to give one of the residents his medication. (Resident #32) Both male residents stated they expressed that they were "indisposed" to the staff, but the staff continued to perform their tasks. They could not recall the staff names or specific dates except both were in the past two weeks. Resident #16	F 241		

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A resident interview with Resident #16 was conducted at 8:30 AM on 5/22/09 The curtain was pulled around the bed to afford Resident #16 some privacy during the interview, per the resident's request. Her roommate was in the bathroom and a certified nursing assistant was providing toileting assistance to that resident.

A staff member, later identified as Employee #12, came around the corner of the curtain and explained she needed to check supplies, specifically disposable briefs. This resulted in the interview being interrupted as the surveyor was required to get out of the chair, and move to the foot of the bed so that Employee #12 could check Resident #16 's closet for briefs.

This employee then knocked on the bathroom door and opened it, and went into the bathroom, again verbalizing she was checking supplies.

An interview with Employee #12 on 5/22/09, revealed that she was in charge of central supply. She stated that she checks supplies such as gloves and incontinent briefs routinely twice a week. She acknowledged she was aware of patient's rights for dignity and privacy. She acknowledged that she should not have interrupted the interview because the need to check for supplies was not something urgent at that time. Although she also acknowledged that when she knocked on the bathroom door, a voice did say yes, that when she opened the door and realized a resident was receiving care, she should have excused herself and closed the door again. Employee #12 stated she always respected residents dignity, but could not explain why she did not do so in this instance.

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An interview with a registered nurse (Employee #14) on 5/22/09, confirmed that staff should not interrupt residents receiving personal care or conversations for non-essential types of activities such as checking supplies. Employee #14 also confirmed that residents in the bathroom, specifically toileting themselves, should not be interrupted to receive non-emergent care such as emptying Foley catheter drainage bags or receiving medications.

Resident #31

A random observation during the initial tour, on 5/18/09 and continued for the duration of the survey revealed that one resident (Resident #31) had a sign that was placed on the outside of the bathroom door by the family. This sign included a request for the staff to place her washed dentures in every day, to use the foot rest on the wheelchair to prevent injury and to change this resident's briefs every two hours. Next to the sign by the family was a weight record form placed by the facility. Both signs had the resident's name on them.

An interview on 5/22/09, with an licensed practical nurse (LPN) (Employee #16) confirmed that these signs contained personal and medical information, that impacted the residents right of dignity and should not have been posted on the outside of the bathroom door where they were visible to anyone entering the room.

During a meal observation, on 5/19/09 at 12:05 P.M., it was noted that Employee #9, a certified nursing assistant, was standing while feeding two residents. The two residents, #28, and #29, were

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F 241	Continued From page 13 in the assisted dining room. Employee #9 stood between the two residents and would turn from one to the other to spoon food into their mouths. There was a empty chair present on the other side of the four resident table and the employee was later observed to be sitting in the chair while she fed another resident on that side of the table. Standing while assisting residents to eat failed to promote resident dignity.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to update the comprehensive care plan for 1 of 29 residents (#9).	F 279		

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Findings include:

Resident #9 was a 93 year old resident who has resided at the facility since November, 2006. Her primary diagnoses were vascular dementia, hypothyroidism and hypertension. Her minimal data sets for the past 15 months revealed that her cognition level has not changed, it remained a two, which indicated "moderately impaired, decisions poor, cues/supervision required".

Record review also revealed that Resident #9 was ordered the following medications:
Aspirin 81 milligrams (mg) daily and Atenolol 50 mg (for high blood pressure) daily since 11/3/06, potassium chloride 10 mEq daily since 7/18/08, all at 8:00 AM and Synthroid 75 micrograms daily at 4:00 PM since 10/10/08.

Review of the medication administration record (MAR) revealed that for the month of March 2009, Resident #9 refused all her prescribed medications on 3/1 and 3/2/09. It also revealed that for the first nine days of March, Resident #9 refused her aspirin, blood pressure medication and potassium, eight of the days.
Documentation for the whole month of March, revealed that Resident #9 refused these medications 13 of the 31 days. Review of the back of the MAR revealed that staff only documented the refusals six of these days.
There was no evidence that staff attempted to offer any of these daily medications at any other times during the day. There was no evidence that the family had been informed of Resident #9's refusals. There was no evidence that the nursing staff increased the frequency for monitoring Resident #9's blood pressure, related to the

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F 279	Continued From page 15 increased frequency of medication refusal. On 3/6/09, the a physician visit note revealed the physician was aware of Resident #9's refusal to take her medicines. There was no change to the plan of care. A review of the care plan initiated 9/19/08, revealed the facility had identified Resident #9's problem of refusing medication. The interventions identified included assessing for more appropriate times to offer/administer the medications and to inform the physician and family. There was no evidence that these interventions were initiated. An interview with the registered nurse (RN) in charge (Employee #6) on 5/18/09, she confirmed that the care plan was not altered even though it was reviewed on 03/06/09.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policies, record review, observation and interviews, the facility failed to ensure that acceptable standards of practice, including professional standards, manufacturer recommendations and facility policies were followed for wound care assessments for 1 of 25 residents (#15). Findings include: Resident #15	F 281		

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Review of the facility policies and procedures revealed that the facility used the Agency for Health Care Policy and Research (AHCPR) regarding pressure sores and wound assessments.

The Wound/Skin Policy, last amended 8/29/05, identified that, "Each resident admitted to the facility will be assessed and monitored for skin condition on a regular basis."
The following points were specified
"#7. When a resident has an open area on admission this will be documented on the Resident Admission form and reported to the wound team
#8. Accurate measurements/documentation will be done weekly during wound rounds.
#9. A Licensed nurse will assess all open areas, Assessment include stage, size, depth, odor, drainage and surrounding skin conditions.
#13. Described the how a wound should be measured, assessments of odor, surrounding skin conditions and causative factors.

The facility policy for pressure ulcer protocol described that assessment of pressure ulcers include the following: Location, size, stage, drainage, odor, color, peripheral circulation and update every seven days to evaluate effectiveness.

Resident #15 was being treated with a wound vacuum system to promote a healing hematoma on her thigh, since her return from the hospital on 4/21/09. The wound vac system applies negative suction pressure to remove any accumulated drainage. A precaution with the wound vac system was to observe the color of the drainage

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F 281	Continued From page 17 being removed, because of the risk of excessive bleeding if a blood vessel breaks due to the suction. An interview with a wound care nurse (Employee #17) on 5/22/09, regarding whether she documented the presence of drainage, odor, or surrounding skin condition if she was performing daily or other frequency wound care, revealed that she did not document the status of any wound whenever wound care was provided, indicating that was the responsibility of the wound care team. Employee #17 acknowledged she did not measure any skin breakdown, including areas of excoriation, skin breaks such as lacerations, rashes or other skin conditions, even if the wound care team was not assessing these types of skin breakdowns. Employee #17 confirmed that she performed wound care to Resident #15, and changed the wound vac system on the days that the wound care team did not assess the wound, and she did not assess the wound or the drainage. An interview with the Director of Nursing who was also responsible for the wound care team, acknowledged that only the wound care team measured wounds being cared for by the wound care team, so that measurement would be consistent. The DON acknowledged that rashes, excoriation, skin lacerations or other skin conditions were not measured. The DON did acknowledge that general wound assessments should be performed whenever wound care is performed.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on facility policy, record review, observations and interview, the facility failed to ensure that residents with wounds or skin breaks received the necessary care, specifically accurate assessments for 4 of 25 residents (#15, #10, #16, #5) and assessments of weight variations for one of 25 residents (#4).

Findings include:

Review of the facility policies and procedures revealed that the facility used the Agency for Health Care Policy and Research (AHCPR) regarding pressure sores and wound assessments.

The Wound/Skin Policy, last amended 8/29/05, identified that "Each resident admitted to the facility will be assessed and monitored for skin condition on a regular basis."
The following points were specified
"#7. When a resident has an open area on admission this will be documented on the Resident Admission form and reported to the wound team
#8. Accurate measurements/documentation will be done weekly during wound rounds.
#9. A Licensed nurse will assess all open areas, Assessment include stage, size, depth, odor, drainage and surrounding skin conditions.

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#13. Described the how a wound should be measured, assessments of odor, surrounding skin conditions and causative factors.

The facility policy for pressure ulcer protocol described that assessment of pressure ulcers include the following: Location, size, stage, drainage, odor, color, peripheral circulation and update every seven days to evaluate effectiveness.

Resident #15

Resident #15 was being treated with a wound vacuum system to promote a healing hematoma on her thigh, since her return from the hospital on 4/21/09. The wound vac system applies negative suction pressure to remove any accumulated drainage. A precaution with the wound vac system was to observe the color of the drainage being removed, because of the risk of excessive bleeding if a blood vessel breaks due to the suction. This wound vac system had been ordered to be changed every third day. Resident #15 also had a central line access for intravenous antibiotic therapy.

An interview with a wound care nurse (Employee #17) on 5/22/09, confirmed that she performed wound care to Resident #15, and changed the wound vac system on the days that the wound care team did not, but she did not assess the wound or the drainage. Employee #17 confirmed she did not documented the presence of drainage, odor, or surrounding skin condition if she was performing daily or other frequency wound care, revealed that she did not document the status of any wound whenever she provided wound care. She replied that was the

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responsibility of the wound care team. Employee #17 confirmed she did not measure any other types of skin breakdown, including areas of excoriation, skin breaks such as lacerations, rashes or other skin conditions.

Review of Resident #15's clinical record on 5/22/09, revealed only the wound care team assessments every week. Weekly skin assessments revealed that skin assessments by the nurse were only documented on 5/1/09, 5/11/09 and 5/15/09 and the central line access was only evaluated on 5/15/09, although it had been in place since Resident #15's return on 4/27/09.

Resident #16

Resident #16 was admitted to the facility on 5/8/09, with primary diagnoses including urinary track infection, debility, multiple sclerosis, and paraplegia. She was assessed on admission at 4:45 PM and it was determined that she had two pressure sores, one on each buttocks, both a stage three. The wound on the right buttock was "a 2 inch open area" and the left buttocks wound was a "one inch open area". (Note: There are 2.5 centimeters per inch.) There was no other description of what the wound beds appearance were, what the depth of the wounds, any odor or drainage or even whether the "2 inch" and "1 inch" measurements were the length or width or an approximate size.

A physicians order was obtained to clean the wounds with wound cleanser, apply Agisite to the wound beds and cover with Allyven every other day. The wound care was started on 5/9/09. There were no further assessments of these

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wounds until the wound assessment team evaluated Resident #16 five days later on 5/14/09.

A wound assessment sheet indicated that Resident #16 was seen by the wound care team on 5/14/09. The wounds at that time were measured to be: The right buttocks 8 x 2 x 1.4 (centimeters) which indicated an increase of more than triple the size initially measured. Resident #16's left buttocks wound was 3 x 3 x 1.2 (centimeters) an increase of almost double. This wound assessment also indicated that there was a wound to the inferior right ischial area which was 5.5 x 1 (centimeter), which allegedly had been observed on 5/8/09, but the first documentation of the wound was on 5/14/09. The physician ordered a change of treatment and dressing frequency from daily to every Monday, Thursday and Saturday on 5/14/09 .

An observation on 5/21/09 revealed an additional area of excoriation on the right buttocks, but there was no evidence that this excoriated area had been observed during the previous wound care provided on 5/14/09 or 5/18/09. There was also no evidence that daily assessments of the patency of the dressings were performed.

Resident #5

Resident #5 was admitted to the facility on 2/11/09, following an acute care hospitalization for acute respiratory failure. Resident #5 continued to require ventilatory support upon her arrival to the facility. Her other diagnoses included chronic obstructive pulmonary disease, anxiety and encephalopathy.

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A review of her clinical record revealed that a skin assessment was performed at 3:30 PM on 2/11/09. At that time, it was documented that in addition to the gastrostomy and tracheostomy sites, five other areas were noted on the skin assessment. These included a puncture wound with a dry dressing on the right antecubital site, purple discoloration around the abdominal area, a dry denuded area and dry flaky patch on the left ankle/foot and thick flaky toenails.

Review of the clinical record revealed that a wound treatment form dated 2/12/09, indicated that on 2/11/09, Resident #5 had two stage two pressure sores, one on each buttocks. This form indicated the pressure sores were present on admission, but the admission record skin assessment or subsequent nurses notes did not indicate the presence of pressure sores.

An interview with the admission nurse (Employee #13) and the wound care nurse (Employee #2) confirmed there was no documentation regarding the pressure sores on admission.

Resident #10

Resident #10 had been a resident since 9/28/01. Her primary diagnoses included senile dementia and information on the initial tour (5/18/09) revealed this resident has had a steady decline of activity and interaction with staff. On 5/8/09, she was found on the floor with a severe laceration to her scalp.

Resident #10 was transferred for emergency care of the head injury and returned to the facility the same day, following repair of the laceration. Resident #10 had a dressing that covered her

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head, and anchored around her chin to secure it. The first visual assessment was done on 5/14/09, during wound rounds. It was revealed that the head laceration was 10 centimeters (cm) long (approximately 4 inches). A second laceration on the forehead was 2 cm long.

A wound care nurse (Employee #21) was interviewed on 5/18/09. She confirmed she performed the wound assessment on 5/14/09. She confirmed there was only a length measurement.

An interview with the Director of Nursing who was also responsible for the wound care team, acknowledged that only the wound care team measured wounds being cared for by the wound care team, so that measurement would be consistent. The wound care team does their wound assessments every Thursday. The DON acknowledged that rashes, excoriation, skin lacerations or other skin conditions were not measured. The DON did acknowledge that general wound assessments should be performed whenever wound care is performed, and that part of the daily assessment of the residents should be assessing dressings to make sure they were intact, that there was no visible drainage or other compromise to the wounds and to ensure there was no deterioration of other skin conditions.

Resident #4

Resident #4 was admitted to the facility on 10/15/08 with a readmission on 3/2/09 following hospitalization for pneumonia. Diagnoses included chronic obstructive pulmonary disease, dysphagia and hypertension.

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In a review of the resident record, it was noted that the resident had previous episodes of lower extremity edema. He was also noted to have had physician's orders for inhalers for shortness of breath. His recent hospitalization was for pneumonia. The weight record indicated that from 3/3 to 3/12/09, that Resident #4 gained 8 lbs and from 3/12 to 3/18/09, he gained an additional 5 lbs. Documentation on the weight record for 3/12/09 indicated that the physician was notified as well as dietary, while on 3/18/09 only dietary was notified of the weight gain. The record did not indicate that any assessment of the resident, by nursing, was undertaken in relation to the weight gain.

In an interview with Employee #6, the Unit Manager, on 5/18/09 at 2:00 P.M., she explained that it was the responsibility of the dietician to determine the cause of the weight gain and to refer the resident to the Weight Variance Committee if the dietician felt that it was appropriate.

In an interview with Employee #2, the Director of Nursing at 8:15 A.M. on 5/19/09, she expressed the opinion that there should have been a documentation of a nursing assessment in regards to Resident #4's weight gain in his record. At 8:40 A.M., Employee #6 then stated that she "had completed a nursing assessment on the resident on a worksheet" after his weight gains and had presented the information to the Weight Variance Committee. Employee #6 acknowledged that she did not document any of her assessment or findings in the resident record and that she destroyed the worksheets after the committee meetings. It was then disclosed that

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F 309	Continued From page 25 there was no actual documentation of the discussions of residents' weight issues in the Weight Variance Committee meetings, only a sign in of the staff attending the meeting. Review of the dietary records in Resident #4's record disclosed that there was no documentation on the resident until 3/23/09, five days after the last weight gain. The dietician indicated the 13 lb gain as being "good." There was no indication if the resident was seen or that any dietary assessment had been completed or as to what the rapid weight gain could be attributed to. The facility policy on Weight Gain and Loss Monitoring stated, " (8.) Minutes of the Weight Variance Committee meeting will be maintained." It was also stated, "(10.) Documentation, including assessment and care planning, will be maintained in the resident's medical record."	F 309		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed ensure that 1	F 325		

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of 30 residents maintained an acceptable weight or was provided appropriate nutritional care and services. (#19)

Findings include:

Resident #19 was admitted to the facility on 3/09/07. He was a double amputee above the knee, due to severe frostbite. Other diagnoses included hypertension depression and chronic obstructive pulmonary disease.

When rhe resident was weighed on 4/1/09, he had experienced a 7.5 lb weight loss from the previous month, weighing only 74.5 lbs. He was re-weighed one week later and had re-gained 1.5 lbs. (76.0 lbs) He was not weighed again until one month later, at which time, he had lost one pound. (75.0) At the time of the 7.5 lb weight loss, the weight record documented that dietary had been notified of the change in his status. There was no evidence in the record that the significant weight loss had been evaluated and assessed by the dietician.

In an interview with a dietician, Employee #22 on 5/21/09 at 9:35 A.M., she disclosed that with a 9.1% weight loss that Resident #19 should have been seen by the dietician. She agreed that the dietary documentation dated 4/9/09, stated that the resident's weight at stabilized at 76 lbs, but did not address that he had 7.5 lb weight loss only one week previously. She also agree that while there was a notation on the resident's care plan for his nutritional status for 4/9/09, there was no evidence that the care plan had been updated or revised to reflect approaches to address Resident #19's recent weight loss.

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F 325	Continued From page 27 The facility's policy for Weight Gain and Loss Monitoring stated that "documentation including assessment and care planning, will be maintained in the resident's medical record." There was no evidence to support that the resident had been review by the Weight Variance Committee. Employee #22 disclosed that she didn't know what happened but that he should have been seen by dietary for the weight loss.	F 325		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		

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Based on record review and interview, the facility failed to ensure that as needed (PRN) psychotropic medications were given with adequate indications for their use for 3 of 24 residents (#6, #18, #23) and to ensure the PRN medication response was documented for 2 of 24 residents (#20, #23).

Findings include:

Resident #6

Resident #6 was initially admitted to the facility on 9/11/07, with a readmission on 4/2/09 with diagnoses including diabetes, dementia, urinary tract infection, hypertension, dysphagia, and history of a cerebrovascular accident. Medication orders included an anti-anxiety (Ativan 0.5 mg) to be given every four hours as needed "for anxiety, restlessness, or distress."

Records for the month of April were reviewed. According to the Nurse's Notes, the as needed Ativan was given on 4/2/09, 4/3/09 (twice), 4/8/09, 4/9/09, 4/10/09 (three times), 4/11/09 (three times), 4/12/09 (three times), 4/13/09, 4/14/09, 4/15/09, 4/16/09, 4/17/09, 4/18/09 (twice), 4/22/09, 4/23/09, 4/24/09, and 4/27/09. The resident's April behavior monitoring form for Ativan was blank accept for the date of 4/27/09 on which the resident experienced restlessness. The resident's PRN record on the back of the Medication Administration Record (MAR) did not include documentation for 14 of the 25 administrations of Ativan for the month of April. Of the 11 administrations listed, just 4 results had been documented.

Resident #6's care plan included the

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statement,"Monitor for s/e (side effects) of meds."

The facility's policy on medication administration, taken from the Nursing Care Center Pharmacy Policy and Procedure Manual, included the following guideline: "When PRN medications are administered, the following documentation is provided: a. date and time of administration, dose, and route of administration; b. complaints or symptoms for which the medication was given; c. results achieved from giving the dose and the time the results were noted; and d. signature or initials of person recording effects."

The unit manager, Employee #23, was interviewed on 5/21/09 at 11:30 AM. She indicated that when a resident was given any PRN medication, both the behavior monitoring form and the MAR were supposed to be filled out, and the documentation on the MAR was to include the reason and result of the medication administration.

Resident #20

Resident # 20 was initially admitted to the facility on 2/7/07, with a readmission on 4/19/08 with diagnoses of renal failure, chronic obstructive pulmonary disease, and depressive disorder. Medication orders included an anti-anxiety (Ativan 0.5 mg) to be given every four hours as needed for crying and restlessness. The resident's care plan included the statement, "risk for adverse reactions from use of psychotropic medications...monitor for s/e of meds." During the month of April, the as-needed Ativan was given, per MAR documentation, on 4/5/09 (twice), 4/7/09, 4/27/09, and 4/30/09. Results of the administration of Ativan had not been

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documented on the MAR.

Resident #18

Resident #18 was admitted to the facility on 12/16/08. Her diagnoses included failure to thrive, hypertension, senile dementia, and anxiety.

The resident had an order for an anti-anxiety to be given every 4 hours as needed. There were no indicators for the use of the medication in the order. The record also contained Medication Administration Records documenting when the medication was given and Behavior Monitoring Forms which were used to document the number of occurrences of the behavior, the interventions employed, and the outcome. The Behavior Monitoring Form indicated that the anti-anxiety medication was to be used for increased restlessness. Records for the months of February, March and April were reviewed.

During the month of February, the as needed anti-anxiety medication was given on 2/5, 2/23, and 2/27 of 2009 without documentation of behaviors on the monitoring form to support the need for the medication to be given for these days.

For the month of March 2009, the as needed medication was given on 3/01 and 3/13 of 2009. Again there was no documentation of behaviors to support the need for the medication.

In April, the medication was given 4/7, 4/8, 4/13, 4/19, and 4/20 of 2009. The medications were given without supporting documentation of behaviors that necessitated the administration of

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F 329	Continued From page 31 the medication.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 334		

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immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to provide comprehensive documentation of the status of the immunizations status for 2 of 30 residents. (#3 and #18)

Findings include:

Resident #3

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Resident #3 was admitted to the facility on 12/10/08, with with a readmission of 4/23/09. Her diagnoses included a fracture of the left scapula, hypertension, vascular dementia and heart failure. She was discharged to home with her spouse during the survey process.

A facility form, the Informed Consent for Pneumococcal and Influenza Immunization, was dated 10/05/07. For the Pneumovax, the form documented that the resident refused the vaccine stating that she was unsure if she had it previously. However, the facility staff documented on the facility Immunization Record that the resident had received the vaccine after age 65. The resident was not aware due to her dementia and it was not possible to determined if the resident had received the vaccine or not based on facility documentation.

Resident #18

Resident #18 was admitted to the facility on 12/16/08. Her diagnoses included failure to thrive, hypertension, senile dementia, and anxiety.

On the facility form, Pneumococcal Immunization, Informed Consent, was a notation, refer to the Dr. (her personal physician) records. The facility's Immunization Record contained no information as to a record search.

An interview was conducted with Employee #23, the Assistant Director of Nurses, at 9:45 A.M. on 5/21/09. She related that the physicians office didn't have documentation of the Pneumovax being given, but that their office's policy is to immunize all their elderly patients. Employee #23

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F 334	Continued From page 34 acknowledged that she failed to document this information on the Immunization Record or to clarify with the facility physician if the resident should be immunized based on the uncertainty of her status.	F 334		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interviews, document and policy review, the facility failed to maintain sanitary conditions for the storage, preparation and distribution of food. Findings include: The state 5/18/09 Food Service Establishment Inspection Report listed the following: 1. At the start of the breakfast tray line at 6:45 AM, pre-cooked sausages had a temperature of 110 degrees Fahrenheit (F). 2. Cantaloupe was observed to be cut without first being washed. 3. The black coating on the top of the back line oven was peeling. 4. The soda gun cups were excessively soiled. 5. The can opener blade was scarred.	F 371		

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6. There were spills noted in the far west pantry refrigerator.

An inspection of the facility's food service operations on 5/19/09 revealed the following:

At the lunch tray line at 12:15 PM, a dietary aide, Employee #18, was observed to wipe her gloved hand on a soiled, dry cloth which was placed at the end of the tray line. She then resumed serving food onto the lunch plates. Upon being interviewed, the employee reported that the cloth was used to wipe off spills from the counter.

At the same time, the cook, Employee #19, was observed to be "multi-tasking" with his gloved left hand, placing it on the counter, wiping it on a towel tied to his waist, and then picking up toast to place it on a plate. The dietary manager, who observed this sequence of events, acknowledged that tongs should have been used to pick up the toast and that gloves should have been changed between tasks.

The facility's policy on safe food handling included the following statement: "Use utensils for handling food whenever possible."

At 2:00 PM a dietary aide, Employee #20, was observed to be placing frozen fish patties on a tray with bare hands. When interviewed, the dietary manager indicated that all dietary staff had been trained to use gloves whenever food was prepared or served. The facility's policy on infection control included the following statement: "It is the policy of the dietary department to practice proper infection control techniques and to train department associates to use these techniques."

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F 371	Continued From page 36 A sanitizer bucket was being stored on a hand washing sink, preventing easy access for hand washing. A wet wiping cloth was being kept on a cart near the tray line, out of the sanitizer bucket, and it was touching a clean tray.	F 371		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain house stock over-the-counter (OTC) medication in the original manufactures' labeling to identify product lot number and expiration date and to remove expired medication.

Findings include:

On afternoon of 5/19/09, the medication cart on the 100 hall was inspected in the presence of licensed practical nurse (LPN) #10. Review of the house stock drawers on the cart revealed a loose single packet of eight divided unit dose Omeprazole DR tablets. The single packet contained only the name of the drug Omeprazole DR and did not include the lot number information or the expiration date. The original manufacturer's box for the Omeprazole DR, which contained the lot number and expiration date was not found on the cart. The LPN agreed that it was not possible to identify an expiration date and if the manufacturer were to recall the product it would not be possible without the product lot number.

An observation of the medication room next to the 300 Hall was made on 5/19/09 at approximately 11:00 A.M. A vial of Tubersol, the material used in administering tuberculin skin tests, was observed in the medication refrigerator. It had been opened and was dated 4/10/09. According to NC TB Control Program Policy Manual (Rev 7/04) , the Tubersol must be discarded 30 days

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F 431	Continued From page 38 after opening.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to enforce controls in order to prevent the development and transmission of disease and infection. Findings include: a) During the medication pass on 300 Hall at approximately 8:30 A.M. on 5/19/09, it was observed that the glucometer was used on three occasions. When the medication nurse, Employee #21, was asked about cleaning of the glucometer, she disclosed that she wiped it off with alcohol if she got blood on it, but that she thought that the night shift did some type of disinfecting. In an interview with Employee #2, the Director of Nurses, she disclosed that each nursing unit had a book containing the documentation of the test controls performed on each glucometer each	F 441		

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F 441	Continued From page 39 night. In addition, in each notebook, was the manufacturer's recommendations for cleaning the meter. Employee #2 further indicated that by signing the documentation that the test controls had been performed, the staff person was also attesting that the glucometer had been cleaned. There was no written documentation or evidence that the cleaning was in fact being done, nor was there written evidence or established policy that staff was aware that cleaning of the glucometer was part of the procedure when the test controls were being completed. b) Observation of the medication cart on 300 Hall at 1:30 P.M. on 5/19/09, revealed an opened can of Nestle Carnation Breakfast. The can was not dated, nor did it have a time indicating when it had been opened. It was not cool to the touch. Manufacturer's directions on the can indicated that it was to be refrigerated after opening. The Carnation Breakfast was a milk based product that would encourage the growth of bacteria when not refrigerated.	F 441		